General Information

This is a solicitation for providers of case management and supports planning services. It is not a grant or a contract. Selected providers will sign the Medicaid provider agreement and be designated as a limited pool of providers of the aforementioned services. There is no financial bid associated with this solicitation.

Current participant enrollment numbers, separated by county, are listed on page 32 of the solicitation in Appendix 1. Page 6 of the solicitation, under the heading of Waiver Registry and Program Applicant and Participant Numbers, provides projections on new applicants and program growth. The Department makes no representations or assurances as to the number of future participants, and the current numbers are provided solely for illustrative purposes.

The current providers and their jurisdictions are listed on page 33 of the solicitation in Appendix 2.

The initial agreement period is January 1st of 2017 through December 31st of 2017.

There are 3 option years available that may be implemented at the discretion of the Department.

Proposals are due no later than 2pm EST on Monday, November 14th in room 136 of 201 W. Preston St. Proposals received after 2pm will not be considered.

The regions and other pertinent information are listed on page 2 of the solicitation. One proposal can be submitted to cover multiple regions. For example, a provider may submit a single proposal that covers 2 or more regions, i.e. Southern region and Montgomery County. For statewide proposals, please clearly label that the proposal is statewide. Please see page 29, section 4.3.2 of the solicitation.

If the provider proposes offering services in multiple regions but there are substantive differences in how the services are provided in each region, then separate proposals are recommended.

However, a provider cannot submit multiple proposals for a single region. For example, if only applying for Baltimore City, only one proposal would be accepted for that region.

Section 4.3.1 on page 29 of the solicitation outlines the requirements for a complete proposal. Please note that a draft final work plan and training plan are required. New agencies should develop draft plans and submit them with the proposal to demonstrate ability to perform the functions. Incomplete proposals may be classified as not reasonably susceptible of being selected for award or the Offeror deemed not responsible.

Please note, as stated in 4.3.2.B on page 29 of the solicitation, that proposals that indicate that a provider "will comply" or "agrees" to each criteria in the solicitation is not adequate. Proposals must include a description of the provider's method and to describe how each requirement will be met. One narrative can cover several requirements, which should be clearly noted, but a statement of agreement by itself will not be considered sufficient. For example, one narrative can describe how all requirements of section 3.5.5, items A-G will be accomplished by the provider. However, listing 3.5.5 "Agreed" or "Will Comply" is not sufficient.

An example of an adequate response for item 3.5.6, which requires that supports planning agencies "Monitor the LTSSMaryland tracking system for completion of the medical assessment by the LHD" would include the person responsible and any process or procedure established to accomplish the task.

Any exception to a requirement, term, or condition may result in having the proposal classified as not reasonably susceptible of being selected for award or the Offeror deemed not responsible.

Any exception that a provider is taking to any requirement of the solicitation should be clearly stated in the proposal. Exceptions should include the specific section numbers and details of the exception. Any alternative proposed by the Offeror should be clearly explained.

Purpose and Background

Background and programmatic information can be found in Sections 1.2 and 1.3 on pages 4-11 of the solicitation.

Providers identified through this solicitation shall provide supports planning to applicants and participants of the CO waiver program, ICS, CPAS, and CFC.

Providers shall coordinate community services and supports from various programs and payment sources to aid applicants and participants in developing a comprehensive plan for community living. Providers shall support applicants in locating and accessing housing options, identifying housing barriers such as past credit, eviction, and criminal histories, and in resolving the identified barriers.

The providers shall assist individuals referred by the Department in developing comprehensive plans of service that include both State and local community resources, coordinating the transition from an institution to the community, and maintaining community supports throughout the individual's participation in services.

There is a resource guide for supports planners available that details all of the policy guidance and training materials for supports planners on the Department's website. The link will be provided in the notes. https://mmcp.dhmh.maryland.gov/longtermcare/pages/Community-First-Choice.aspx

Please read these materials prior to developing and submitting a proposal. The information on the website will clarify the responsibilities and expectations for supports planning agencies.

Materials available include regulations, supports planner training materials, program forms and fact sheets, and policy manuals. All supports planners are required to be familiar with the content of these materials prior to beginning work with participants.

We are not providing a demonstration of the LTSSMaryland tracking system today, however, there are several recorded webinars on using the system that will provide detailed instruction and screen walk through of selected sections of the current system. These webinars are available at http://www.ltsstraining.org/. Most of interest to potential providers is the webinar on Waivers or Supports Planning Selection. Additional training will be offered to selected providers as part of the required Departmental training prior to serving participants.

Changes from Previous Solicitations

- Removed the requirement for 24 hour phone support
- Added required training for new supports planners
- Increased the maximum allowable caseload ratio to 1 case manager to 55 applicants or participants.
- Removed agency-set caps on referrals.
- Incorporated previously issued guidance on billing, ISAS, and conflicts of interest that existed in the addendum

24 hour Phone Access
The requirement for 24 hour phone access was removed from the solicitation. Existing agencies will no longer be required to offer 24 hour access to a supports planner. The solicitation still requires that agencies return all routine, non-emergency calls within one business day from the time the message is recorded in item 3.2.21. Agencies must also have a clear communication path that is shared with participants as required in 3.2.23.
It is also required that supports planners work with participants through a person-centered process to develop emergency back-up plans as noted in 3.5.19 and 3.5.33, and to assist participants in registering with emergency services, if desired (3.5.32).

Training
This solicitation requires that all supports planners attend the new supports planner training offered by the Department within 90 days of hire or at the first opportunity if no training is offered within 90 days. This requirement is designed to improve quality and consistency across providers and the system. The Department is still working on options for reimbursing providers for this training time. At this time, there is no established payment or rate for attending training.

Supports Planner Ratio
This solicitation also increases the maximum allowable ratio to one supports planner to 55 applicants or participants. This only increases the maximum allowable ratio and does not require or encourage agencies to use this ratio for all staff. Well-trained staff with established relationships with participants or experience in transitions may be able to successfully support the higher number of people. New supports planners with little experience are not expected to sustain the maximum allowable number of

individuals. Proposals should include the agency's proposal for distributing assignments. For example, new supports planners may need to maintain the minimum ratio for the first 6 months.

Agency Capacity
This solicitation does not ask providers to set their own capacity limits. Supports planning provider capacity has been an ongoing limiting factor in the programs. We have not been able to serve as many people off of the registry as planned because of the limits on the current provider network. This solicitation requires that agencies accept all referrals, so that all individuals who are entitled to services can access them in a timely manner and without unnecessary delays. The historical Living at Home and Older Adults waiver programs used this method for their networks to assure capacity.
This new requirement applies to providers identified through this solicitation. It does not currently apply to Area Agencies on Aging.
Any exception to this requirement should be clearly labeled and stated in the proposal in response to requirements 3.5.1 and 3.5.2.

Billing
This is a provider solicitation, not a procurement or grant, so there is no financial proposal. The only reimbursement for services is through fee-for-service billing. There are no start-up payments or additional funding beyond the service rate.

The supports planning services rate is set in regulation and is currently $15.17 per 15-minute unit which equates to $60.68 per hour.

All billing is done exclusively through the LTSSMaryland tracking system.

Newly selected providers will not be able to begin billing on day 1. All supports planners must complete training prior to being assigned participants to serve. Supports planning providers must have their training plan approved by the Department and must participate in Department-led training prior to initiating services.

One of the changes in this solicitation that is different from prior versions is that billing guidance is now incorporated in section 3.11 starting on page 24. This guidance is not new, but incorporates existing billing policies into the solicitation.

Billing guidance includes limitations for supports planners. No more than 7/8ths of the workday may be billed as there are non-billable activities in any given workday (lunch, breaks, travel time, etc.).

Conflicts of Interest
Maryland's participation in the Balancing Incentive Program requires that we implement and maintain a conflict-free case management system.

Conflicts of interest are addressed in the solicitation in the following areas.

- The definition of conflict of interest is in the proposal in 1.1 H on page 3.
    - *Any real or perceived incompatibility between an agency or agency employee's private interests and the duties of this Solicitation.*
- Minimum Qualifications in Section 2.1.4 on page 12.

- Section 3.2.2 on page 13.
- Section 3.9 Conflict Free Case Management on page 24.

Potential providers who are also providers of other long-term services and supports, regardless of payer, must disclose this potential conflict of interest in their proposals. As supports planning agencies assist applicants and participants in choosing from any willing provider, there is potential conflict for a supports planning provider who also offers other services. Any relationship with other provider agencies must also be disclosed. For example, if the spouse of the Director of the supports planning agency owns, operates, or is on the Board of another provider agency, the relationship must be disclosed and any conflict must be remediated.

One possible way to remediate conflict of interest would be to propose to stop providing the other services or to dissolve business relationships that create conflict if awarded as a supports planning provider through this solicitation.

If the conflict cannot be clearly resolved, a remediation and monitoring strategy are required to be submitted with the proposal. Remediation plans should include ongoing monitoring of the conflict and responsible parties.

For example, if there is a relationship with another provider agency, a plan might include data analysis of the use of the other provider to determine if there is disproportionate use of that provider across the agency's plans of service. Frequency of monitoring, responsible parties, administrative separations, escalation of the remediation plan if issues are discovered, and other details of the remediation strategy should be included. For example, if the data shows that there is disproportionate use of the related agency's services, the supports planning agency should have a plan beyond monitoring to resolve that documented conflict.

Q and A from previous solicitations

1. Is the LTSSMaryland tracking system for billing only?
    a. No, the LTSSMaryland tracking system has both record keeping and billing functions.
2. Is there a cost to use the LTSSMaryland tracking system?
    a. No, it is free.
3. Can a person who is on call or provides care 24 hours a day have access to the system?
    a. There would need to be a business associate agreement with HIPPA language. Subcontractors are allowed.
4. How many providers is the state looking for through this solicitation?
    a. There is no specific target number of providers. The state is looking to expand choice for participants and applicants and to ensure that the system has enough capacity to serve all eligible applicants.
5. How many clients can an agency expect on day 1?
    a. We cannot predict referrals for a single agency. It will depend on how many providers there are and how many people select each of those providers. Current participant enrollment numbers, separated by county, are listed on page 32 in Appendix 1. Page 6

of the solicitation, under the heading of Waiver Registry and Program Applicant and Participant Numbers, provides projections on new applicants and program growth. The Department makes no representations or assurances as to the number of future participants, and the current numbers are provided solely for illustrative purposes.

6. Does being awarded this solicitation provide a license?
    a. There is no license; the state is looking to create a limited pool of providers. Only providers who are awarded through this process can provide services.
7. If you have a residential service agency, would this be a conflict of interest?
    a. Yes. BIP requires conflict free case management, so it needs to be very clear in the proposal how the agency would remediate the conflict. Please refer to sections Section 3.2.2 on page 13 and Section 3.9 Conflict Free Case Management on page 24.
8. If you are a DDA or BHA provider of residential services, can you apply?
    a. Yes, but you have to address how you would remediate the conflict of interest.
9. Do we build staffing and overhead into our proposal?
    a. There is no financial proposal or payment for these costs associated with this solicitation. The state will not provide any additional administrative money or reimbursement beyond the rate for supports planning services.
10. Do you have a training manual?
    a. There is a resource guide for supports planners available that details all of the policy guidance and training materials for supports planners on the Department's website.
11. Can you describe the referral process to the supports planning agency?
    a. Referrals will be made via the LTSSMaryland tracking system as noted on pages 7 and 8 of the solicitation. Applicants will be given information to choose an agency, they will call the agency, and the agency will go in to LTSS and select themselves. If the participant hasn't selected an agency after 21 days they will be auto-assigned. The auto-assignment is done via round robin for all providers available in the jurisdiction. Current participants may choose to change their provider as well.
12. Can we submit our proposals electronically?
    a. We require paper submission. Submission guidelines are on page 29 in section 4.3. An additional electronic copy may be sent to the dhmh.cfc@maryland.gov email address; however, the electronic submission will not meet the deadline requirements and will not be reviewed in the absence of the paper copies submitted timely as required in 4.3.
13. Are there any estimates on how many hours of service an individual requires?
    a. It varies greatly based on needs. On average, 2-4 hours per month are billed per person. This increases during crisis, transition, and redetermination. This number will be lower for people who need less support.
14. Is billable time direct or indirect?
    a. There is some indirect time that is billable, but it has to be a service to the participant. Travel time is not billable, and you can't bill when a person is receiving another Medicaid service. Please see the billing guidance in section 3.11.

15. Will there be additional training?
    a. Yes, based on the needs of awarded providers. There is policy training for supports planners and additional training on the use of the LTSS system. Please see the resource guide online for details of new supports planner training at the following link. https://mmcp.dhmh.maryland.gov/longtermcare/pages/Community-First-Choice.aspx
16. Can an agency target a certain population?
    a. No. Any provider must serve all applicants and participants referred or assigned to the agency regardless of diagnosis or disability.
17. Who guides a person in the institution through selecting a supports planning agency?
    a. We don't have a 3rd party designated to this task. They can call the Department or the MAP site or call the supports planning agencies for additional information.
18. How do we address things like staffing standards?
    a. There is no template, but submit as much detail as possible. Resumes, job descriptions, and other materials could be used to demonstrate this requirement.
19. Do we need to name the staff in the proposal?
    a. Yes, please include names and submit resumes of proposed staff.
20. What about recruitment?
    a. Include the job description, plan for hiring, etc. with the proposal.
21. What if there is just one employee?
    a. Include the job description, plan for hiring additional staff, etc. in the proposal.
22. Are SPAs responsible for recruitment for CFC, CPAS, etc.?
    a. No, interested people contact the Department or the Maryland Access Point (MAP). A referral made to the local health department and supports planning packets sent out with the brochures of all enrolled providers in that region. If they don't choose an agency by Day 21, they are auto-assigned based on capacity. The SPA receives an alert that they have a new referral.
23. Do offerors need to be a current Medicaid provider?
    a. No. Selected providers will be enrolled as Medicaid providers.
24. Do we need a special pediatric license?
    a. No.
25. Is LTSS training included?
    a. Yes, the Department offers up to 2 days of direct training on the tracking system at no cost to the provider upon enrollment. Ongoing training on the use of the system for new staff will be the responsibility of the provider. Please include this in your training plan as part of the proposal.
26. Can we use DHMH training materials?
    a. Yes. However, additional provider materials are expected to include all items in 3.2.17 on page 14.
27. Can we refuse participants?

   a. No, must serve any and all individuals who are referred. This includes people of all disabilities and children.
28. Can we expand to other regions later?
   a. Yes, with Departmental approval and if the agency has no active corrective action plans.
29. Why do you need more SPAs?
   a. We need to expand capacity for new interest and to ensure an adequate network and choice.
30. What kind of license do you require?
   a. None.
31. Do you need a Medicaid provider number?
   a. Yes, but that can happen after selection. Current provider numbers cannot be used to bill for these services. A new provider number will be assigned.
32. What do you do if you don't have language capacity?
   a. There is a Limited English Proficiency (LEP) policy for DHMH on the website. You must provide translation services for any referral in accordance with the LEP policy. If you don't have language capacity, please state in your proposal how you plan to address this.
33. What do you do if you don't have a toll free number?
   a. If you don't have a toll free number, submit a plan to get one with proposal.
34. Are you required to hire nurses?
   a. No, but SPAs need access to a RN as referenced in 3.2.9.
35. Do you have a sustainability study?
   a. No.
36. How long for feedback after the proposals are submitted?
   a. It depends on the number of proposals and other factors. A decision will likely take at least 30-60 days.
37. Do you review proposals before the deadline for submission?
   a. No.
38. What if you have unpaid staff involved in the work?
   a. Any resource must be included in proposal or we will assume that you don't have it.
39. Do we need to submit a letter of interest?
   a. No.
40. Do we submit a brochure in proposal?
   a. Yes. Please submit an agency brochure if you already have one and/or a mock-up of a brochure for this effort to demonstrate ability to meet the requirement.
41. How established does an agency have to be?
   a. We don't have a minimum standard; we look at capacity and capability. The proposal must show capacity and capability and compliance with the minimum qualifications.
42. Question about Section 3.2.3- Does the office have to be wheelchair accessible?

a. Yes, you must have a place to meet with clients that meets the ADA requirements. Put your plan in the proposal.

43. Do you need to respond to every item?
    a. Yes.
44. Can an RSA providing personal care to participants in the community be a support planning and case management agency at the same time?
    a. It is unlikely that an agency licensed as an RSA and providing Medicaid-funded personal assistance would be able to meet the minimum qualifications in Section 2.1 and remediate conflicts of interest as required in section 3.9.
    First, the RSA would have to meet the minimum qualification of providing case management services that were not ancillary to the provision of personal assistance. The case management experience must be beyond the case management provided in conjunction with another service in order to meet this minimum qualification.

    Second, the agency must be free from conflicts of interest, which are defined as "Any real or perceived incompatibility between an agency or agency employee's private interests and the duties of this Solicitation" in the definitions on page 3 in section 1.1 H.

    Section 3.9 requires conflict-free case management services. The provision of other services may present perceived conflicts in the potential for self-referrals or manipulation of hours of service that would benefit the provider. Employing or maintaining other business relationships with providers of Medicaid services could also be perceived as a conflict of interest.
45. Is there a requirement to have a physical office location in each region?
    a. No.
46. Is a new POS required when a participant changes providers?
    a. Yes. Provider changes that do not change the cost of the plan auto-approve.
47. Who pays for the OTP device?
    a. The Department provides OTP devices at no cost to providers or participants.
48. How is time submitted if an OTP device is lost?
    a. Providers must continue to log-in via the ISAS when the OTP is missing or not working. The supports planner is required to report the loss and replace the device within 72 hours as noted in item 3.6.7 on page 23 of the solicitation. OTP devices are provided to the SP Agencies, free of charge, in advance for distribution to the participants as needed.
49. How do supports planners verify accurate billing?
    a. The LTSSMaryland tracking system has My Lists and reports that agencies use to monitor and verify billing entries. It is the agency's responsibility to monitor activities entered by the staff for accuracy and compliance with regulations and Departmental guidance.

50. What are allowable services to be billed?
    a. Services that are billable are outlined in sections 3.2-3.7 and in the Billing section of 3.11 starting on page 24.
51. What is the purpose of the 1:20 minimum caseload ratio?
    a. The minimum ratio is based on current usage history and the number of supports planning hours typically received.
52. What is the average nurse monitoring visit frequency?
    a. The nurse monitoring hours recommended and received varies widely and changes often based on the participant's needs, medical condition or disability, and presence of any nursing services or required delegation. Participants can waiver nurse monitoring down to 2 contacts per year.
53. What is the length of a nurse monitoring visit?
    a. The length of each visit varies widely and changes often based on the participant's needs, medical condition or disability, and presence of any nursing services or required delegation. Frequent visits may be shorter and annual visits are often longer.
54. Can an independent RN or licensed social worker be subcontracted?
    a. Yes, nurses and social workers must be available to the agency but do not need to be full-time employees. Contracts can be used. Proposals should contain the detailed plans for meeting this requirement either through staffing or contractual relationships.
55. What are the data elements in the LTSSMaryland module available for the supports planning agencies to use?
    a. We do not have a data dictionary to share at this time. All fields in the system are available but there is no data export available to providers.
56. Does LTSSMaryland system allow for electronic upload of activity or provider billing information?
    a. No. All activities and billing must be manually entered in the system. No data imports or exports are allowed or available.

New Questions

1. Are reference letters required or just names?
    a. We prefer reference letters with contact information.
2. Are resumes sufficient or are short blurbs required?
    a. Resumes are acceptable, but blurbs are preferred.
3. Do existing agencies have to resubmit all employee information?
    a. Yes. In an addendum is acceptable.
4. What are acceptable exceptions to agency cap on referrals?
    a. We do not have specific exception criteria. The agency needs to explain why they are requesting the exception. Any alternate plan for expansion in the future should be included in the proposal.
5. Where should the request for exception on no referral limit be?

   a. The request must be made in response to sections 3.5.1 and 3.5.2. An exception to any requirement can also be noted in the beginning of the proposal.
6. Do you know how many referrals we should expect in the future?
   a. No. We can only predict from past years and provide historical data. The programs have increased by 1,400 individuals in the last year. Current participant enrollment numbers are listed on page 32 of the solicitation in Appendix 1. Page 6 of the solicitation, under the heading of Waiver Registry and Program Applicant and Participant Numbers, provides projections on new applicants and program growth. The Department makes no representations or assurances as to the number of future participants, and the current numbers are provided solely for illustrative purposes.
7. Are you able to divide those 1,400 by county?
   a. It may be possible, but the Department may not be able to provide that breakdown within the timeframes for this solicitation.
8. Are we currently serving all who are eligible?
   a. Yes
9. How you do you know you are serving all eligible clients?
   a. We are currently serving all those who have been referred and are eligible. There is no CFC waiting list.
10. Can you explain why there are no limits or registries for CFC/CPAS?
   a. CFC is a State plan entitlement program, therefore, we cannot establish a waiting list for services. Anyone who is eligible (and meets financial, technical and medical requirements) is able to access services through CFC. CO is under a different authority, therefore we can create registry.
11. Can you clarify the solicitation item that says SPs cannot bill during another Medicaid service?
   a. There is no limitation in the current solicitation about billing during other services. However, SPs should only bill for time as described in the billing section 3.9.
12. Can we bill while client is at MDC?
   a. Yes, if the service meets the billing requirements in 3.9. For example, the service must be at least 8 minutes not including travel time or supervision.
13. If an agency has 10 SPs and 550 consumers, but the agency receives an additional referral, will there be a grace-period for the agency being over the case ratio limit?
   a. Yes, we will work with agency to get back into compliance with the required ratios. Each agency should have a plan for expansion and managing growth so that any instances of non-compliance with the support planner ratio are temporary and managed with an expansion and quality plan.
14. How will new referrals be handed out in the future with no capacity? Will referrals instantly jump up?
   a. Referrals are assigned to agencies via a round robin process per region. Referrals are distributed by region in which the applicant lives. There is not a backlog in the system, so sudden spikes or a high number of referrals are not likely. The number of referrals to

any single agency will depend on regions served, the number of other providers in each region, and the flow of referrals from the community and nursing facilities. However, large numbers could come from a supports planning agency provider disenrolling. In this instance, the provider has a 6 month transition period to reassign participants to other providers.

15. How do agencies handle the payments for their managerial and administrative staff who don't bill?
    a. Existing agencies do not pay the full Medicaid reimbursement amount directly to the billing supports planners and use a portion of the revenue generated from the supports planner billing to cover their administrative costs.
16. Are current providers required to apply for this solicitation again?
    a. Yes. All providers must meet the same standard. Existing providers are not guaranteed to continue to be providers. This is a competitive process and all offerors will be evaluated on the same criteria.
17. Do existing providers need to resubmit the work plan and training plan?
    a. Yes. Providers can resubmit prior plans they propose to continue, and must address any new information or requirements in the solicitation. All sections of the solicitation need to be addressed.
18. Is the expectation that a new SPA would begin on 1/1/17?
    a. The Department aims to make awards by January 1, 2017. New providers have start-up time and should include start-up time and costs in their proposals and proposed work plans. New providers are expected to begin providing services after the hiring and training processes are complete within calendar 2017. If the provider wishes to start at a later date beyond the base year for the award through this solicitation, such as in 2018 or 2019, they would need to postpone a proposal for a later solicitation.
19. Section 3.12.1 requires a proposed start up work plan. Is that applicable for current providers?
    a. Yes, all offerors must complete and submit a proposal in response to the solicitation. This is a competitive solicitation process and existing providers are not guaranteed an award.
20. How soon would a new SPA be billing? Would all Supports Planners be required to attend Department training first?
    a. The billing start date will vary based on provider readiness. A provider with staff and experience that could be trained quickly, within the month of January, and may be able to begin billing for services fairly soon. A provider that must identify and hire new staff will be delayed while executing the work plan. Yes, supports planners will need to attend Department training prior to providing services to any applicants or participants. Training will be scheduled with each new provider individually.
21. Will Department training be available in January 2017?
    a. Yes, for new agencies.
22. What are the billable hours for Supports Planners?

   a. It varies greatly depending on the individual. Billing for participants averages around 2-4 hours a month. Some Supports Planners bill the full 7/8 of a work day consistently.

23. Can you provide the number of agency brochures that will be needed for the solicitation period?
   a. Yes, but we will need to pull a number based on jurisdiction and these numbers may not be available prior to the proposal due date.
24. Is it a conflict of interest if an agency has common ownership of RSA?
   a. Yes, this is a potential conflict and would need to be disclosed and addressed in the proposal.
25. Can services be shared with another SPA if one has strengths in a certain area?
   a. No, a supports planning agency must demonstrate in their proposal that the agency can meet all of the requirements of the solicitation. An agency can include subcontractors or partners in its proposal, but a single agency must be the lead agency responsible for all components of the solicitation. It is not possible in LTSS to assign a client to two SPAs at one time. The system is designed for a single supports planner and a single point of contact for each participant to maintain consistency and accountability.
26. Can this information be sent in Word instead if PDF?
   a. Yes.
27. Do people get assigned units for billing?
   a. A projection of Support Planning billing is added to POS, but is not a limitation on the hours of service provided or paid. Participants or applicants may have changing needs and the amount of supports planning will need to be flexible to accommodate these changes. There is a hard limit of 7 hours per participant, per day as well as the 7/8ths limitation on a supports planner's work hours.
28. Do newly hired SPs with supports planning experience need to attend Department training?
   a. Yes, unless there is documentation they have attended the Department's training in the last year.
29. Can you clarify the SP requirements on experience and education? Are they required to have both?
   a. The requirement allows for education or experience to fulfill the requirements. However, if there is any concern about meeting the minimum qualifications, agencies should send the resume and exceptions request to the Department for review.
30. Is it a conflict of interest if a SPA has other MA funded services outside of this contract?
   a. Yes, it should be disclosed as a potential conflict of interest and a remediation plan should be submitted with the proposal.
31. Are waiver forms for SP qualifications no longer needed?
   a. The waiver forms for supports planner qualifications are still required if an agency is requesting Departmental approval to hire a person who does not meet the minimum requirements outlined in the solicitation.
32. Do the AAAs need to sign the acknowledgment form?
   a. Yes.

33. Can we still send questions until there is no longer reasonable time for the Department to respond?
    a. Yes. No phone inquiries; questions are only accepted in writing. Written question can be emailed to Dhmh.cfc@maryland.gov
34. Can you include in the proposal how office space will be acquired?
    a. Yes. If an offeror does not currently have the resources required for the solicitation, such as office space, staffing or interpreter services, the solicitation should clearly outline the plan for securing the needed resources within the first few months of the award period. Documentation, such as job descriptions, contracts contingent on award, or other agreements should be included with the proposal to demonstrate ability to meet the solicitation requirements.
35. Is office space not a requirement?
    a. It is not required to have an office in every jurisdiction you serve. However, requirement 3.2.3 requires an accessible meeting space.